

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016791

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 2043 Registrar's No. 143

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0640

2 05602

3

4 0

5 1

6

7 1

8 0

9 420.1

10

11

12 91-2

13 1-0

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LEWIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>OAKWOOD</u>		c. CITY OR TOWN <u>LEWISTOWN</u>	
Length of stay in 1b <u>1 WEEK</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1800 29th. street</u>		d. STREET ADDRESS (If outside, give location) <u>XXXXXXXXXXXXXXXXXXXXXXX</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>GOODWIN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/80</u>
9. AGE (last birthday) <u>82yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXXXXXXXXXXXXXXXXXX</u>	
11. BIRTHPLACE (City and state or country) <u>LIMA, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES GOODWIN</u>		13b. MOTHER'S MAIDEN NAME <u>ALMIRA TRIPP</u>	
14. NAME OF HUSBAND OR WIFE <u>MAMIE GOODWIN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>XXXXXXXXXXXX</u>		17. INFORMANT <u>MRS. ED GOODWIN</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	
20g. COUNTY <u> </u>		20h. STATE <u> </u>	
21. I attended the deceased from <u>June 1952</u> to <u>16 April 63</u> and last saw her/him alive on <u>14 April 63</u> Death occurred at <u>D.O.D.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>John W. Webb, D.O.</u>	
22b. ADDRESS <u>Lewistown Mo</u>		22c. DATE SIGNED <u>18 April 63</u>	
23a. BURIAL, CREMATION, or other final disposition (Specify) <u>BURIAL</u>		23b. DATE <u>4/19/63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LEWISTOWN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>LEWISTOWN, MISSOURI</u>	
24. NAME AND ADDRESS OF EMBALMER <u>Charles F. Arnold, Jr. LEWISTOWN, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>April 22, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luche by Lillian M. Norman</u>		27. SIGNATURE OF REGISTRAR <u> </u>	

(Licensed Embalmer's Statement on Reverse Side)

MAY 1 1963

0000
0000

10

01-5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles L. Arnold, Jr.

Licensed Embalmer No. #4667

P. O. Address LEWISTOWN, MISSOURI

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit issued 4/22/63